FAIRFAX COUNTY HEALTH DEPARTMENT – SERVICE SLIP

PATIENT NAME: _____ **DOB/:** ____/____/____ **PIN:** _____

BELOW TO BE COMPLETED BY HEALTH DEPARTMENT STAFF ONLY: (Note: * see flow sheet)

☐ Patient Pay/FAMIS **Guarantor 1**	☐ Medicaid **Guarantor 2**	☐ Anthem **Guarantor 13**	☐ Amerigroup **Guarantor 15**

CPT Codes	Catch Up	Vaccine	ICD-9-CM Codes	ADM Fee	MFG	Lot #	Dose/Route	SOI	Funding Source Code V-S-C-A-P-E	VIS Date
90700*		DTAP	V06.1				0.5 / IM			
90696		DTAP-IPV	V06.1				0.5 / IM			
90636		HEP A/HEP B TWINRIX	V05.3				1.0 / IM			
90632		HEP A - Adult	V05.3				1.0 / IM			
90633		HEP A - (Child 1 thru 18)	V05.3				0.5 / IM			
90746		HEP B – ADULT	V05.3				1.0 / IM			
90744		HEP B – (Child 0 thru 19)	V05.3				0.5 / IM			
90647		HIB (Ped Vax)	V03.81				0.5 /IM			
90648*		HIB	V03.81				0.5 /IM			
90649*		HPV (quad)	V04.89				0.5 /IM			
90281		IMMUNE GLOBULIN	V07.2				/ IM			
90738		JAPANESE ENCEPHALITIS	V05.1				/ IM			
90707*		MMR	V06.4				0.5 / SQ			
90710*		MMRV (12 mos. thru 12 yrs.)	V06.8				0.5 / SQ			
90733		MENINGOCOCCAL POLY	V03.89				0.5 / SQ			
90734		MENINGOCOCCAL CONG (11-55 YRS.)	V03.89				0.5 / IM			
90723		PEDIARIX (HEPB/DTAP/IPV)	V06.8				0.5 / IM			
90698*		PENTACEL (DTAP/IPV/Hib)	V06.8				0.5 / IM			
90670*		PNEUMOCOCCAL *Conjugate (VFC Eligible)	V06.8				0.5 / IM			
90732		PNEUMOCOCCAL (POLYSACCHARIDE)	V03.82				0.5 /IM			
90713*		POLIO INJECTABLE	V04.0				0.5 /IM			
90675		RABIES	V04.0				1.0 /IM			
90680*		ROTAVIRUS (ROTATEQ) (VFC Eligible Only)	V04.89				2.0 / PO			
90681*		ROTAVIRUS (ROTARIX) (VFC Eligible Only)	V04.89				1.0 / PO			
90714*		TD	V06.8				0.5 / IM			
90715		TDAP	V06.8				0.5 /IM			
90691		TYPHOID INJECTABLE	V03.89				0.5 /IM			
90690		TYPHOID – ORAL	V03.89				/ PO			
90716		VARICELLA	V05.4				0.5 / SQ			
90717		YELLOW FEVER	V04.4				0.5 / SQ			
90736		ZOSTER	V04.89				.65 /SQ			
86580		TST GIVEN	795.5							

TST CODES (Circle for current TST entry): **TYPE: INITIAL / REPEAT / BOOSTER** **TIME PLANTED:** _____

_____ _____ ***SERVICE TIME (Minutes):*** _____ ***CHECKOUT:*** _____

START TIME - (Ready for PHN) *PROVIDER'S SIGNATURE* *(Time Spent with PHN)* *(Front Desk)*

INTERPRETER: _____ ***DATE:*** _____

(Name/Number)

TST READ: _____**MM** **DATE:** _____ **OUTCOME:** ☐ ***Positive*** ☐ ***Negative*** ☐ ***Unreadable*** ☐ ***No Return***

_____ _____ ***SERVICE TIME (Minutes):*** _____ ***CHECKOUT:*** _____

START TIME - (Ready for PHN) *PROVIDER'S SIGNATURE* *(Time Spent with PHN)* *(Front Desk)*

INTERPRETER: _____ ***DATE:*** _____

(Name/Number

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RECORD KEEPING

I understand that medical records will be retained for six years after the date of the last visit or for five years following patient's death. In the case of a minor, the record will be retained ten years after the last visit or for five years after age 18, whichever comes later.

PATIENT CONSENT FOR GENERAL PRIMARY CARE

I hereby authorize the Physicians, Nurses, Nurse Practitioners, and other medical care providers of the Fairfax County Health Department (FCHD) to examine and/or treat me and/or my dependent, as named above.

DOCUMENTATION OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices from the Fairfax County Health Department.
www.fairfaxcounty.gov/hd/privnote.htm

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

FCHD is required by § 32.1-45 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any FCHD health care professional, worker or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to the blood or body fluids of a FCHD health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

HIV TESTING

If HIV testing is performed, you will be told ahead of time, be given information about the test, and allowed to decline testing. All results will remain confidential except as allowed by law.

I understand that this consent will remain in effect as long as my dependent or I receive care from FCHD or until I withdraw it.

_____ _____
Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis Date Signed

COMMONWEALTH OF VIRGINIA
VOTER REGISTRATION AGENCY CERTIFICATION

If you are not registered to vote where you live now, would like to apply to register to vote here today?
(Please check only one)

☐ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
☐ Yes, I would like to apply to register to vote. (Please fill out the voter registration application form)
☐ No, I do not want to register to vote.

_____ _____ _____
Applicant Name Signature Date

PERMISSION TO SHARE SCHOOL AGED STUDENT'S IMMUNIZTION RECORDS

"I authorize Fairfax County Health Department (FCHD) to release information relating to any and all immunizations received by my child/dependent at the FCHD with school systems for the express purpose of meeting school entrance requirements."

_____ _____
Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis Date Signed

BELOW TO BE COMPLETED BY HEALTH DEPARTMENT STAFF ONLY:

CODE	LABORATORY	CODE	OTHER SERVICES	CODE	OTHER SERVICES (CONT.)
84030	HEMOGLOBIN	COU	COUNSELING STD/IMM	S0250	NURSING HOME SCREEN
86706	HEPATITIS B SCREENING	HSI	HOMELESS SHELTER INITIAL	DDW	DD WAIVER
86703	HIV TESTING	HSR	HOMELESS SHELTER RETURN	90471	ADMIN FEE-INITAL
83655	LEAD SCREENING	IDC	INFANT DEVELOPMENT	90472	ADMIN FEE-ADDITIONAL
81025	PREGNANCY TEST FP/MAT	MRX	MALARIA RX	99211	OFFICE VISIT
		RSO	RISK SCREEN ONLY	99402	IT CONSULTATION FEE
		PHA	PH ASSESSMENT	CODE	TATTOO PROGRAM
		ODOT	Office Directly Observed Therapy	15783	TATTOO REMOVAL

Your Privacy is Important!

Fairfax County understands your privacy is important. Government rules require Fairfax County agencies providing health services to you to protect the privacy of your health care records. Your records include your personal information that can identify you. The health care worker will write in your record information about your health and what treatment you had while they took care of you. If the health care worker wants you to get more services that information will be written in the record too.

Our policy has always been to keep your records safe. We follow the strongest laws that protect your health care information. This poster describes the rights you have from the government rule, the Health Insurance Portability and Accountability Act (HIPAA). We must let you know how we follow this rule.

Sometimes federal and state laws will change. If the government rules change, Fairfax County and our agencies, boards, and commissions reserve the right to change our privacy policies and any of our privacy practices at any time. These changes will apply to all of the health care records we keep safe for you.

A Summary of Your Privacy Rights:

- You may ask us to contact you at work or at home. We will try to follow all reasonable requests.

- You have the right to request a copy of your electronic medical record. You can look at your health care record or ask for a copy of the record we keep about you. If we think you may have a bad reaction to some content in the record, we can say no.

- If you think there is something wrong or missing in your health record, you may ask that it be changed. We do not have to make the change, but we will work with you to include your concerns.

- We may need to show your health record to other people. A law may require us to share your information. We will only share your information when there is a good reason to do so. If you do not want us to share your information with certain people you must let us know. We will try to follow your instructions, but we do not have to do so all the time.

- You may ask for a list of all of the people with whom we shared your information. This list will not include times we shared your information with other health care workers about your treatment, for your bill payment, or for our service management. The list will not include those times you said it was OK to share your health information.

- To learn more about your rights and how we may share your information you may request a complete copy of the Notice of Privacy Practices. You may request this notice at any time. One will be given to you when you get health service from us.

- You have the right to be notified in the event that we discover a breach of your unsecured protected health information.

- You may write us a letter or e-mail if you think we have violated your privacy rights. Our HIPAA Compliance Manager or the Federal Department of Health and Human Services can help you with your complaint.

For more information about Fairfax County's HIPAA Compliance Program, please contact:
HIPAA Compliance Manager
12000 Government Center Parkway, Suite 527 | Fairfax, VA 22035
Phone: (703) 324-4136 | **TTY**: (703) 968-0217 | **Web:** www.fairfaxcounty.gov/hipaa